MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, September 12, 2002
10:14 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: Public comment

MR. HACKBARTH: We'll now have a brief public comment period.

MS. CUEVO: Good afternoon. My name is Acela Cuevo and I'm here on behalf of the Coalition for Access to Medical Services, Equipment, and Technology. CAMSET is a coalition of consumer advocacy groups and professional and trade associations. We have serious concerns about the appropriateness of competitive bidding as a model for the DMEPOS benefit.

We want to emphasize a few of the points that were raised by the Commission. In particular, we believe that the data that has come out of the demonstrations on competitive bidding remains very limited, and that in fact it may not be transferable to the DMEPOS benefit nationally as a permanent program for the Medicare beneficiaries.

As some of you noted also, competitive bidding may reduce access, reduces access to items that require services. It's important to remember though that you need to understand very carefully what the services are and what their impact are on the clinical outcomes for patients.

For example, oxygen is one item that was addressed a number of times in the discussion. Patients who receive oxygen therapy require ongoing monitoring by respiratory therapists. They need access to on-call services because this is a life-supporting therapy that they're receiving in the home. Patients and their families need training on the use of oxygen and troubleshooting so that they know when to call. And there is a need for an environmental assessment of the home to make sure that it can be safely provided in the home. That's just a highlight of some of the important services that are required for this therapy. Of course, there are other services that include the routine maintenance and switching of equipment when it is broken and responding timely to those calls.

Many rehab products, and these include wheelchairs are individually prescribed and require a great deal of fitting and customization. So really it is very important to understand what services go with what products and why they are important for the health of beneficiaries.

The other point to note is that the service standards that are part of the demonstration really do not reflect the standards that are required in the private sector generally, and we believe there remain some very serious questions about quality and service and standards in the demonstration.

Beyond that, I think it was mentioned that the demonstrations present an administratively complex model. Competitive bidding is administratively complex and it really is not clear what the impact of savings competitive bidding can have. CAMSET has some studies on these two issues and I will make them available to the Commission. We certainly would like to work with the Commission in addressing any further questions you may have. Thank you.

MR. GRAEFE: Fred Graefe with Hunton & Williams representing Invocare, a manufacturer of home medical equipment, and my client

is also a member of Acela's trade association.

First of all, I thought the presentation by staff was excellent and the discussion was excellent. I would like to bring some real world reality to you, however, that this is not an academic discussion. This is a very real issue today on Capitol Hill. The President proposed nationwide competitive bidding in his budget this year. The House Medicare bill passed earlier this year includes nationwide competitive bidding based on that two-year study done in Polk County, Florida.

The Senate is now wrestling with that same issue of whether it should include competitive bidding in its Medicare bill this year or whether it should extend the demonstration authority which was granted, as staff pointed out, in 1997 to do up to five projects. CMS only started two. It's completed none, and there is no final report.

So I think you heard from your excellent staff today about some of the good things and a lot of the bad things, or premature conclusions that one could make. I'm urging you to reconsider waiting until 2003 because this issue is being decided today on Capitol Hill, and it's not unreasonable to expect that the Commission may receive a missive from somebody in the Senate requesting, since you've begun a study of it, to give the Senate Finance Committee your views as to the strengths and weaknesses of doing national competitive bidding for all of DME products, even those requiring extensive servicing. And there are several hundred products, not just five categories -- based on the two-year study in Polk County, Florida. San Antonio has one year, and as you heard there is no study yet, let alone a final report on this whole project.

Dr. Reischauer mentioned the administrative cost. CMS has told people in response to written questions, they said, we expect no increase in administrative infrastructure to implement national competitive bidding for DME. It takes about, I think -- Nancy-Ann, correct me if I'm wrong, but probably 300 to 400 FTEs at CMS today to administer a similar appropriate, the Medicare+Choice. Is that wrong?

MS. DePARLE: That is wrong.

MR. GRAEFE: It is wrong. I asked somebody at CMS today in the administrator's office and that's the answer they gave me. But it's more than one but less than 300. So there will be an administrative cost to this. There is no reference to that at all. There's no reference to access to beneficiaries, and more importantly, the effect on competition. This may be an effect of the collision when Senator Durenberger was on the committee of antitrust policy with health policy.

Lyncare controls a leading oxygen supplier; 70 percent of the oxygen market in Polk County, Florida. When this project is completed in three to five years, basic economics tells you that there won't be any more market power for Medicare. There will only be one major supplier left.

So all of these questions need to be addressed. It needs further study. It's premature, I think, to use a two-year study in Lakeland as a model. So I urge you to recognize that it has some real world application today for health policy, which is the

reason Congress created you and wants your advice and counsel and discussion.

Thank you very much.

MS. WILBUR: My name is Valerie Wilbur and I work with the social HMO consortium which represents the four social HMO sites. I'd like to share with the organization written comments on the report that was submitted in 2001 so I don't take up a lot of time here. But I would also like to just point out a couple discrepancies that the social HMO consortium with the report. I would also like to thank Tim Greene for acknowledging that the report itself indicated that there were some shortcomings and that some of the period of time that was used to study, some of the outcomes that were reported could have been longer.

I guess as a general comment in terms of overall comment I'd like to say that the consortium was disappointed that the report to Congress didn't look at some of the original protocols we set out to try to prove, like were we successful in keeping people out of nursing homes, were we cost effective in terms of reducing costs in other parts of the system like Medicaid by either keeping people out of nursing homes or keeping them from spending down. Those kinds of things weren't looked at.

In terms of health status which Tim talked about, the biggest concern we have about health status is that it indicated that the social HMO folks weren't any frailer or sicker than other M+C plans in the areas that they served, but yet in 1999 CMS itself published a report based on Health of Seniors data which was used by MPR and CMS to make the conclusion about health status, which came to a completely different conclusion.

What the CMS 1999 Health of Seniors data reported was that social HMOs had higher proportions of older members, which of course is an indicator of risk, more reporting poor self-health, more reporting decline in health from the previous year, more with ADL impairments than comparison groups, both at the national and state levels. It went on to conclude that after adjusting for age, gender, and health outcomes, the 1999 reports conclude that on the basis of several physical and mental function scores Elderplan, the New York plan, had the frailest members of all 24 New York M+C plans, Kaiser had the frailest of all 14 plans in Oregon, and SCAN members had the second most frail of 39 plans in the state of California.

We hired an outside actuary to figure out why did Health of Seniors in '98 tell us one thing but HHS report comes out and tells us something completely different. What he concluded was that when MPR did the analysis they did the analysis at the county level instead of the state level, which resulted in smaller pools of people and had a greater likelihood of showing a bias in some of the outcomes. Also that MPR only adjusted for age, sex, and Medicaid status. That is didn't look at comorbidities and study design which the CMS study looked at the year before.

I think that when Congress passed BBA and said, let's come up with risk adjustment it was acknowledging that demographics like age and sex alone aren't a sufficient indicator of risk. Hence, let's include the diagnostic factors. So we have a

disagreement with the conclusions that come out.

The reason this is so critical is because the report then goes on to say, based on these conclusions, we don't think these plans warrant any different payment structure than the standard M+C plans, and we don't think it's fair that they are paid more than they would have been paid if they were a standard M+C plan. We believe that because, for example, the first generation programs have 20 to 30 percent nursing home certifiable, that they in fact do have higher risk levels as the 1998 data showed from CMS, and that they do warrant a higher payment.

The other point I wanted to make is the final report that Tim referred to only focuses on Sierra Health Plan of Nevada. It's only going to look at one of the four plans. It won't look at the first three plans. When we had requested that when they come out with the final report, if they would go back and make some changes that some of the staff at CMS themselves acknowledged could have been interpreted differently, they said that this report would only focus on the second generation social HMO.

In terms of beneficiary satisfaction, which was a question that was raised, my sense is, from reading the report that beneficiary satisfaction within the S/HMOs was about the same as it was for all M+C plans, but it didn't look at any of the special features of the social HMO to see if the beneficiaries and their caregivers would benefit from some of the extended care benefits, the access to greater case coordination. In fact Senate bill 2782, which was introduced about three weeks ago will do -- if it's passed, require special beneficiary satisfaction that will look at the special programs offered by S/HMOs as well as whether caregivers were more satisfied because they got extra support.

On the queuing, Tim mentioned at the beginning of time, we wouldn't be different because we were allowed to queue to keep our risk levels down. It's been at least seven years since any of the social HMOs have employed the queuing. Once they learned how to do care management they dropped that and they haven't been doing that in many years.

Then the Senate bill also would require MedPAC to do a cost effectiveness study to see in fact whether social HMOs are cost effective. It lays out some things they could look at like whether they kept people out of nursing homes, kept people from spending down, how their costs stacked up relative to other benefit levels for comparable case mix, that sort of thing.

So those are my brief comments. I will send more detailed comments but I just would ask that you might take a second look at some of these issues and I thank you very much.

DR. ROWE: I'd like to ask a question or two because some of that went past me pretty fast and it's been a long time since I've looked at this. Are you saying that institutionalization or admission to a long term care facility was not a dependent variable in the study, that it was not measured? I thought it was measured. Are you saying that --

MS. WILBUR: Let me put it in lay terms, if I may, so I don't give you the wrong answer. The study did not look at

whether the social HMOs were effective in keeping people out of nursing homes or delaying the time at which they would enter so that maybe they'd be in the community a year or two before they otherwise would have.

DR. ROWE: The members of your consortium at the outset of the social HMO experiment designed the experiment along with the federal government, right?

MS. WILBUR: Yes, sir.

DR. ROWE: So that if that's an important outcome measure that should have been included --

MS. WILBUR: Yes, sir, that's what we felt.

DR. ROWE: -- members of your consortium were around the table when the outcome measures were agreed upon; is that right?

MS. WILBUR: No. No, we had no -- we actually requested input in the study design and we had no input in the study design, sir. We in fact have done some of our own studies and some other universities have done studies that show that our programs, that the members of our programs are 40 to 50 percent less likely to go into nursing homes for a long stay, meaning more than 60 days.

DR. ROWE: The second thing is, I thought I heard you say that the patients were basically sicker.

MS. WILBUR: Yes, sir, that's what the CMS 1998 Health of Seniors data showed.

DR. ROWE: I guess I would just mention that, getting back to my earlier comment, then I think that would make it that much more likely that you would have been able to show a beneficial effect, not less likely. Because in fact the sicker the patients were, the more frail they are, the more disability they have, the more likely they are to benefit from the intervention. So if in fact it was said that they weren't sicker but you feel they actually were sicker, then that would have made it that much more likely that the intervention would have been effective.

MS. WILBUR: But they only looked at health outcomes on one plan, sir, and it was only for a year of time. It was when Sierra first came into being. They hadn't fully implemented their interventions. The two universities that did the study under CMS study said that even if the geriatric interventions had been fully in place, within the first year that they wouldn't have been reasonably expected to have an impact. They didn't look at health outcomes for the other three, not after 1989.

DR. ROWE: Thank you.

MR. GORSKI: My name is Walt Gorski and I represent the American Orthotic and Prosthetic Association. Our membership includes the patient care facilities that provide orthotic and prosthetic devices as well as the manufacturers of orthotic and prosthetic devices. I'd like to thank the Commission and the commissioners for raising some serious questions about alternative pricing and specifically competitive bidding.

Our association has several concerns with the prospects of mandating competitive bidding for orthotic and prosthetic services. We believe that farming out health care services simple to a low or lowest bidder is unwise. That the upshot will be that it will restrict access to trained providers who are

skilled in the provision of orthotics and prosthetic devices, and it will affect the long term quality of orthotic and prosthetic services.

Let me just give you a little bit of background about how O&P is paid for under the Medicare program. We receive one lump sum payment for all the services related to the provision of an orthotic device. What that includes is, once we get a prescription from the physician the orthotist or prosthetist evaluates the patient's medical condition. They then design, fit, fabricate, or customize that device to the individual patient. The payment also includes the device payment itself as well as 90 days of follow-up care.

What we foresee happening under a competitive bidding model is that what will happen is you'll reduce or just eliminate the professional services associated with the provision of these types of devices. What this will do is that it will give some suppliers who have little or not training in the provision of orthotics and prosthetics a real advantage in the bidding process. That's what the real issue here is. It has to do with the quality and access to.

If you put forth a competitive bidding program what we think will happen is that you will have untrained providers providing these types of devices and that orthotists and prosthetists who are specifically trained for this will be the losers in this model, and ultimately the beneficiaries will be the ones who suffer.

Id' like to address one of Dr. Reischauer's issues with this and that had to do with, by lowering the device payment you're lowering the copayment for the beneficiary. Essentially, that may be what you find in the short term or on paper. What could potentially happen is that you will have untrained providers putting these types of devices on patients but that if the device is fitted improperly and the patient needs to see a physician or they have to, if it results in hospitalization which some of these cases can do, you'll actually be increasing Medicare's costs.

I think my time is running out but let me at least offer my association as a resource to MedPAC as you move forward with your recommendations. Thank you.

MR. HACKBARTH: Thank you.